SERFF Tracking Number:	*SKML-126108237*	*State:*	*Arkansas*
Filing Company:	*Kanawha Insurance Company*	*State Tracking Number:*	*42484*
Company Tracking Number:	*90840*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/90840*		

Filing at a Glance

Company: Kanawha Insurance Company

Product Name: Hospital Indemnity Policy	SERFF Tr Num: SKML-126108237	State: ArkansasLH
TOI: H14I Individual Health - Hospital Indemnity	SERFF Status: Closed	State Tr Num: 42484
Sub-TOI: H14I.000 Health - Hospital Indemnity	Co Tr Num: 90840	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Alvah Shelton, Pamela Kelly	Disposition Date: 06/02/2009
	Date Submitted: 05/27/2009	Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Hospital Indemnity Policy

Project Number: 90840

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/02/2009

Deemer Date:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: This form is being submitted to the state of domicile simultaneously with a nationwide filing.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 06/02/2009

Corresponding Filing Tracking Number: 90840

Filing Description:

Hospital Indemnity Policy, Form No. 90840 AR

Hospital Confinement Daily Benefit Rider, Form No. 90841 AR

Application for Hospital Indemnity, Form No. 1664

Outline of Coverage for Hospital and Medical Indemnity Policy, Form No.1675 AR

SERFF Tracking Number:	*SKML-126108237*	*State:*	*Arkansas*
Filing Company:	*Kanawha Insurance Company*	*State Tracking Number:*	*42484*
Company Tracking Number:	*90840*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/90840*		

The enclosed forms are being submitted on behalf of Kanawha Insurance Company for your review and approval. These forms are new and do not replace any forms currently on file with your Department.

This form will be marketed primarily through career agents

The Hospital Indemnity Policy, Form No. 90840 AR, pays a lump sum benefit for a Covered Person's Hospital Confinement, Emergency Room Treatment, or Outpatient Surgery. This policy does not provide reimbursement for expenses incurred.

Hospital Confinement Daily Benefit Rider, Form No. 90841 AR, pays a daily benefit amount for each full day a Covered Person is confined in a hospital. It also provides a benefit for each day the Covered Person is confined in the hospital's intensive care unit. No benefits are payable for more than 30 full days for each Hospital Confinement.

Application for Hospital Indemnity, Form No. 1664, will be used with the policy and rider forms. The Company may also alter this form for use in electronic format; however, the overall style and appearance of the application will remain the same.

The Outline of Coverage form No.1675 AR will be used with the policy, rider and application forms in accordance with the requirements of your state (if any).

The forms are in final printed form subject only to changes in font style, margins, page numbers, ink and paper stock. For example, formatting may change slightly when the document is assembled through an automated document assembly system. Printing standards will never be less than those required by law. Once approved, the Company reserves the right to use the forms in their approved format in a variety of media, including the Internet, with the understanding that there may be slight accommodations made for electronic viewing.

All bracketed numbers are variable to the extent by your state's laws. All bracketed text is variable to the extent allowed by law. In addition, the bracketed text may or may not be included in the policy when printed. In no event will numbers or text be changed to impact compliance with your law.

While every effort is made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors or minor grammatical errors noted after the filing and approval.

SERFF Tracking Number:	*SKML-126108237*	*State:*	*Arkansas*
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Product Name:	*Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/90840*		

Company and Contact

Filing Contact Information

(This filing was made by a third party - sandrakmeltzerandassociates)

Alvah Shelton, Policy Analyst
1925 Century Blvd
Atlanta, GA 30345

alvah@skminc.com
(404) 633-5353 [Phone]
(404) 633-6301[FAX]

Filing Company Information

Kanawha Insurance Company
210 South White Street
Lancaster, SC 29720
(803) 283-5301 ext. [Phone]

CoCode: 65110
Group Code: -99
Group Name:
FEIN Number: 57-0380426

State of Domicile: South Carolina
Company Type: Life
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	There is a fee due of $50 per filing of all related forms. This filing contains one policy and the forms included are related.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Kanawha Insurance Company	$50.00	05/27/2009	28119155

SERFF Tracking Number:	*SKML-126108237*	*State:*	*Arkansas*
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Product Name:	*Hospital Indemnity Policy*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/02/2009	06/02/2009

SERFF Tracking Number:	*SKML-126108237*	*State:*	*Arkansas*
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Project Name/Number:	*Hospital Indemnity Policy/90840*		

Disposition

Disposition Date: 06/02/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SKML-126108237*	*State:*	*Arkansas*
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Form	Hospital Indemnity Policy	Approved-Closed	Yes
Form	Hospital Confinment Daily Benefit Rider	Approved-Closed	Yes
Form	Application for Hospital Indemnity	Approved-Closed	Yes
Form	Outline of Coverage For Hospital Indemnity Policy Form 90840 AP	Approved-Closed	Yes

SERFF Tracking Number:	*SKML-126108237*	*State:*	*Arkansas*
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Product Name:	*Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/90840*		

Form Schedule

Lead Form Number: 90840 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	90840 AR	Policy/Contract/Fraternal Certificate	Hospital Indemnity Policy	Initial		50	HI Policy Final _90840_ AR.pdf
Approved-Closed	90841 AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Hospital Confinment Daily Benefit Rider	Initial		50	Hosp Conf Daily Benefit Rider Final _90841_ AR.pdf
Approved-Closed	1664	Application/Enrollment Form	Application for Hospital Indemnity	Initial		50	1664 App Final.pdf
Approved-Closed	1675 AR	Outline of Coverage	Outline of Coverage For Hospital Indemnity Policy Form 90840 AP	Initial		50	Outline of Coverage _90840_ Final AR.pdf

THIS IS A LIMITED BENEFITS POLICY

KANAWHA INSURANCE COMPANY

[210 S. WHITE STREET]
[LANCASTER, SC 29720]

[PO BOX 610]
[LANCASTER, SC 29721-0610]

TELEPHONE: [877-207-0158]

HOSPITAL INDEMNITY POLICY

We will pay the benefits provided by this Policy upon Our receipt of Proof of Loss incurred while this Policy is in force. We will also provide the other rights set forth in this Policy.

Signed for the Company.

[]

[President]

30 DAY RIGHT TO EXAMINE POLICY

During the first 30 days after You receive this Policy, if You decide that You do not want it for any reason, You can return it to Us. If returned within 30 days of receipt, this Policy will be considered void as though it was never issued and any Premium paid will be refunded. If You return this Policy, include a written notice telling Us of Your decision. Send to one of the above addresses.

GUARANTEED RENEWABLE TO AGE 70

You can keep this Policy until the Policy Anniversary date after the Primary Insured's 70th birthday. You must pay each Premium due before the end of the Grace Period. Your Premium can be changed, if We change the Premium on all policies in Your Policy's Premium class. Premiums also vary depending on state of residence. If You move, Your Premium may change.

This is a limited Hospital Indemnity Policy
Premiums may be changed
Non-participating

PRE-EXISTING CONDITIONS EXCLUSION. Except for congenital anomalies of a covered Dependent Child, no benefits are paid for any care or treatment that occurs during the first 12 months of this Policy for any Pre-existing Condition.

This Policy is a legal contract between You and Kanawha Insurance Company.

90840 AR

PLEASE READ YOUR POLICY CAREFULLY!

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IMPORTANT NOTICE

Please read the copy of Your Application that is attached to and a part of this Policy. This Application may have been captured electronically or on paper. This Policy was issued on the basis that the answers to all questions shown on the Application are correct. Please carefully review these answers to make sure they are correct. If an error exists, please notify Us immediately.

If You need to contact someone about this Policy for any reason, You may contact Kanawha Insurance Company at the addresses shown on the front page of this Policy or by calling [1-877-207-0158].

POLICY SCHEDULE

Coverage Plan Type:	[Family Coverage]
Policy Owner:	[John Doe]
Primary Insured:	[John Doe]
Age:	[35]
Date of Policy:	[09/01/2005]
Policy Number:	[1234567890]

PREMIUM

	Premium
Hospital Indemnity (Base Policy)	[$#,###.##]
[Hospital Confinement Daily Benefit Rider]	[$#,###.##]
Total Annual Premium	[$#,###.##]
Premium Payment Mode	[Monthly Bank Draft]
Total Modal Premium	[$#,###.##]/[Month]

[Notice: A collection fee of [$12.00] annually will be applied to all policies billed by credit card. This fee may be changed annually.]

BENEFITS

Base Benefits

Hospital Confinement Lump Sum Benefit Amount	[$500]
Emergency Room Treatment Lump Sum Benefit Amount	[$150]
Outpatient Surgery Lump Sum Benefit Amount	[$150]

[**Rider Benefits:**]

[Hospital Confinement Daily Benefit Amount]	[$50]
[Intensive Care Unit (ICU) Daily Benefit Amount]	[$200]

DEFINITIONS

Age means age as of last birthday.

Applicant means the person who signed the Application requesting coverage.

Application means the application signed by the Applicant and submitted to Us for this Policy.

Calendar Year means the period starting on the Date of Policy and ending on December 31st of that same year. Thereafter, Calendar Year is the period starting on January 1st and ending December 31st of the same year.

Conversion Policy means a new policy of insurance issued by Us that:
- provides coverage most nearly similar to the coverage contained in this Policy;
- covers one or more Eligible Dependents; and
- only covers persons who were Covered Persons under this Policy.

A Conversion Policy is only available as stated in the Conversion section of this Policy.

Covered Person(s) means each person, including the Primary Insured, covered by this Policy as an insured person. Each person named in the Application as a person proposed for coverage is a Covered Person unless excluded by Us when this Policy was issued. Covered Person(s) includes each Eligible Dependent who is later added to this Policy and approved by Us as a Covered Person. Benefits under this Policy are only paid for Covered Persons. Each Covered Person's coverage ends as provided in this Policy.

Date of Application means the date the Applicant signed the Application for this Policy.

Date of Policy means the date shown on the Policy Schedule or in an endorsement to this Policy.

The Date of Policy will be used to determine:
- effective date of coverage;
- Premium due dates;
- the time limit on certain defenses, except as otherwise stated; and
- as may be provided in this Policy.

Dependent Child/Dependent Children means the natural children and adopted children of the Primary Insured and/or of the Primary Insured's spouse who:
- are less than 18 years of Age or are less than 26 years of Age if a full-time student;
- are unmarried; and
- have not contributed more than one-half toward their own support during the prior Calendar Year.

An adopted child would include a child legally placed for adoption with the Primary Insured or with the Primary Insured's spouse.

Disabled means the inability to engage in self-sustaining employment due to mental incapacity or physical handicap.

Doctor means a medical doctor or doctor of osteopathy who:
- is licensed to practice medicine by the state or U.S. territory in which services were provided;
- is acting within the scope of his or her medical license when services are rendered; and
- is practicing in the United States or its territories.

A Doctor does not include a Covered Person's spouse or a person related to a Covered Person as a child, sibling, parent or parent-in-law.

Eligible Dependent(s) means those persons, other than the Primary Insured, who may be provided coverage by this Policy. The Plan Type that You chose on the Application determines which, if any, Eligible Dependents can be covered by this Policy.

Eligible Dependents are:
- the Primary Insured's spouse;
- the Primary Insured's Dependent Children; and
- the Primary Insured's spouse's Dependent Children.

Only those Eligible Dependents named in the Application and approved by Us are covered under this Policy, unless later added and approved by Us as a Covered Person pursuant to the terms of this Policy.

Emergency Room Care means medical treatment of a Covered Person that:
- is by or under the direction of a Doctor;
- is due to a Sickness or Injury;
- is provided in a Hospital emergency room;
- results in a fee being charged; and
- unless provided at once, would jeopardize the Covered Person's life or cause serious damage or impairment to one or more of the Covered Person's bodily functions.

Grace Period means the 31 consecutive day period starting on the day the Premium is due during which You can pay the Premium and during which coverage is effective.

Hospital means a properly licensed operating facility which:
- is primarily and continuously engaged in providing on-site medical, diagnostic and major surgical services for the medical care and treatment of sick or injured persons;
- provides medical care under the supervision of a staff of one or more duly licensed Doctors;
- provides care on an inpatient basis for which a charge is made; and
- provides 24 hour nursing services by or under the supervision of one or more registered nurses.

A Hospital is not a facility which provides primarily:
- convalescent, nursing, or extended care;
- custodial, educational or rehabilitory care;
- care of mental or nervous disorders; or
- care for the aged, drug addicts or alcoholics.

Hospital Confinement means one continuous period of confinement of a Covered Person that:
- occurs in a Hospital as an inpatient;
- is for the treatment of an Injury or Sickness; and
- for which a Hospital room and board fee is charged.

Injury means accidental physical bodily damage sustained by a Covered Person which:
- is independent of all other causes; and
- occurs while this Policy is in force.

Outpatient Surgical Procedure(s) means a surgical procedure that is:
- performed on a Covered Person;
- performed by a Doctor;
- due to an Injury or Sickness; and
- one for which an overnight Hospital stay is not required.

[**Plan Type** means either:
- coverage for an individual (Individual);
- coverage for an individual and his or her Dependent Children (Single Parent); [or]

- coverage for an individual, his or her spouse and their Dependent Children (Family)[.][;] [or]
- [coverage for an individual and his or her spouse (Couple).]]

[Plan Type is the coverage option You chose on the Application.]

Policy Anniversary means the yearly anniversary of the Date of Policy.

Policy Owner means the Applicant, who is the owner of this Policy. If the Applicant and the Primary Insured are not the same person and should the Applicant die before this Policy ends, the Primary Insured shall become the Policy Owner.

Premium means the amounts that must be paid to Us for coverage under this Policy and to keep this Policy in force.

Pre-existing Condition means any Injury, Sickness or condition of a Covered Person for which he or she received treatment or for which treatment was advised or recommended by a health care provider within the period of 12 months prior to the Date of Policy. It is also a condition for which symptoms existed during the same 12 month period prior to the Date of Policy which would cause a reasonably prudent person to seek diagnosis, care or treatment.

Primary Insured means the person listed on the Policy Schedule.

Proof of Loss means written evidence that supports benefits are due under the terms of this Policy. Proof of Loss may include Doctor's statement(s) and Hospital bill(s), supported by medical records, if requested.

Sickness means an illness or disease of a Covered Person, including pregnancy and childbirth. Waiting Period(s) and exclusions may apply.

Us, **We** and **Our** means Kanawha Insurance Company.

Waiting Period(s) means that period of time starting on the Date of Policy during which no benefits are payable for care or treatment of certain conditions, medical procedures or Sicknesses.

You and **Your** means the Policy Owner.

BENEFITS

Subject to all terms in this Policy, We will pay the benefits provided by this Policy. An expense must be incurred that is for the care or treatment of a Covered Person. It must be due to an Injury or Sickness and must occur after the Date of Policy. The care or treatment must be the type for which this Policy provides benefits as stated herein.

Benefits are only due and payable for a loss covered by this Policy for which Proof of Loss has been received by Us.

Proof of Loss must be submitted.

This Policy does not provide reimbursement for the expense(s) incurred, but provides the below listed benefits based upon a Covered Person receiving covered care or treatment for which an amount is charged.

Benefits are paid to the Primary Insured, unless assigned.

Benefits are only paid for care or treatment of Covered Persons occurring while this Policy is in force.

Hospital Confinement Lump Sum Benefit

We will pay the Hospital Confinement Lump Sum Benefit Amount shown on the Policy Schedule for each Hospital Confinement of a Covered Person.

No benefits are provided or paid for more than one Hospital Confinement for each Covered Person per Calendar Year.

Each Hospital Confinement must be under the supervision of a Doctor.

Hospital Confinements of a Covered Person for the same or related Injury or Sickness shall be considered a single Hospital Confinement, unless separated by a period of at least 180 consecutive days.

A Hospital Confinement which starts in one Calendar Year and continues into the next Calendar Year shall be considered to be a part of the Calendar Year in which it started.

Emergency Room Treatment Lump Sum Benefit

We will pay the Emergency Room Treatment Lump Sum Benefit Amount shown on the Policy Schedule when a Covered Person visits a Hospital emergency room and requires and receives Emergency Room Care.

No benefits are provided or paid for more than two such Hospital emergency room visits for each Covered Person per Calendar Year.

The following maximums also apply:

- [no more than three such Hospital emergency room visits for all Covered Persons per Calendar Year if this Policy provides Couple Plan Type coverage;]
- no more than four such Hospital emergency room visits for all Covered Persons per Calendar Year if this Policy provides Single Parent Plan Type coverage; and
- no more than six such Hospital emergency room visits for all Covered Persons per Calendar Year if this Policy provides Family Plan Type coverage.

No benefits are provided or paid beyond maximums.

For Emergency Room Care due to Injury, the Covered Person must visit the Hospital emergency room and receive the Emergency Room Care within 72 hours of the Injury for benefits to be payable.

Outpatient Surgery Lump Sum Benefit

We will pay the Outpatient Surgery Lump Sum Benefit Amount shown on the Policy Schedule when a Covered Person requires and undergoes an Outpatient Surgical Procedure for which a fee is charged.

No benefits are provided or paid for more than two such Outpatient Surgical Procedures for each Covered Person per Calendar Year.

The following maximums also apply:

- [no more than three such Outpatient Surgical Procedures for all Covered Persons per Calendar Year if this Policy provides Couple Plan Type coverage;]
- no more than four such Outpatient Surgical Procedures for all Covered Persons per Calendar Year if this Policy provides Single Parent Plan Type coverage; and
- no more than six such Outpatient Surgical Procedures for all Covered Persons per Calendar Year if this Policy provides Family Plan Type coverage.

No benefits are provided or paid beyond maximums.

If a Covered Person undergoes more than one Outpatient Surgical Procedure during a single visit, only one Lump Sum Outpatient Surgery Benefit will be paid.

MAKING A CLAIM UNDER THIS POLICY

Notice of Claim

A written notice of claim must be given to Us within 60 days after a covered loss starts or as soon thereafter as is reasonably possible. A covered loss is an event or occurrence of care or treatment for which benefits are provided under the terms of this Policy.

The notice of claim should include:
- the Covered Person's name;
- Policy number; and
- a description of the claim.

Send the written notice of claim to:

Kanawha Insurance Company
[Post Office Box 2000]
[Lancaster, South Carolina 29721-2000]

If We do not require that claim forms be submitted, the written notice of claim along with the Proof of Loss will be used to process the claim.

Proof of Loss

Proof of Loss showing dates of loss must be given to Us within 90 days after the covered loss starts. If You are not able to give Proof of Loss within 90 days, Proof of Loss must be given to Us as soon as is reasonably possible. In any event, Proof of Loss must be given not later than one year from the time the covered loss starts, unless You are legally unable to do so.

We have the right to defend any claim for benefits under this Policy and to investigate any such claim. We may require authorizations to obtain medical and psychiatric information as well as non-medical information.

Payment of Benefits

Benefits due will be paid to the Primary Insured, unless We have received written notice that benefits have been assigned. Any benefits due and unpaid at the Primary Insured's death may be paid, at Our option, either to his or her estate, or a beneficiary, if one was named for this Policy.

If benefits are payable to an estate or to a beneficiary who cannot execute a valid release, We can pay benefits up to [$1,000] to someone related to the Primary Insured by blood or marriage whom We consider to be entitled to the benefits. Any payment made in this manner fully discharges Us and releases Us from further claims for the benefits paid.

LIMITATIONS

Waiting Period(s)

Six Months
No benefits are provided or paid under this Policy for care or treatment occurring during the first six (6) months from the Date of Policy due or related to (unless on an emergency basis):

- cancer;
- hernia(s); or
- adenoids, tonsils or appendix.

Ten Months

No benefits are provided or paid under this Policy for care or treatment occurring during the first ten (10) months from the Date of Policy due or related to:

- pregnancy; or
- childbirth.

Twelve Months

No benefits are provided or paid under this Policy for care or treatment of any Covered Person donating an organ occurring during the first twelve (12) months from the Date of Policy.

EXCLUSIONS

No benefits are provided or paid under this Policy for any loss, expense, care or treatment due or related to:

- intentionally self-inflicted Injury;
- suicide or any attempted suicide, whether sane or insane;
- mental or emotional disorders without demonstrable organic disease;
- Injury or Sickness incurred as a result of engaging in an illegal occupation;
- voluntary ingestion, injection, inhalation or use of any drug, narcotic or sedative, unless prescribed by and taken in accordance with the directions of the prescribing Doctor;
- voluntary ingestion, injection, inhalation, taking, absorbing or use of any poison, poisonous gas, fumes or any other substance that results in Injury or Sickness;
- being intoxicated as intoxication is defined by the laws of the state in which the incident occurred;
- alcoholism or drug addiction;
- war, whether declared or undeclared;
- cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to trauma, infection or other diseases of the involved part; and reconstructive surgery because of congenital disease or anomaly of a covered Dependent Child which has resulted in functional defect;
- elective surgery not medically necessary, other than organ donation and complications related to organ donation after the Waiting Period;
- dental services or dental treatments unless necessitated by trauma or Injury;
- Injury or Sickness incurred as a result of being engaged as a paid athlete;
- participation in a riot, felony or insurrection;
- travel in, on or descending from any kind of aircraft, unless as a fare paying passenger on a commercial airline, passenger on a private airline charter or as a passenger on a privately owned and operated airplane that seats more than 10 passengers;
- sky diving;
- eye examinations, eye glasses, hearing aids or the fitting thereof; or
- care or treatment received outside of the United States or its territories.

The following which may be related to pregnancy are excluded from coverage under this Policy and no benefits are provided or paid for any care, treatment or claim due or related to:

- an elective abortion;
- false labor;
- occasional spotting;
- Doctor prescribed rest; or
- morning sickness.

Complications of pregnancy will be treated the same as any other Sickness.

Pre-existing Condition Exclusion – Except for congenital anomalies of a covered Dependent Child, no benefits are provided or paid under this Policy for any loss, care or treatment that occurs during the first 12 months of this Policy for any Pre-existing Condition.

COVERAGE

Each person named in the Application as a person proposed for coverage is a Covered Person unless excluded by Us when this Policy was issued. Coverage for persons named in the Application who are not excluded by Us begins at 12:01 a.m. standard time in the Covered Person's state of residence on the Date of Policy.

Coverage ends as stated in this Policy. See the Termination of Coverage section.

COVERAGE OF ELIGIBLE DEPENDENTS

If You chose a Plan Type on the Application that allows coverage for Eligible Dependents, all such Eligible Dependents named in the Application as persons proposed for coverage are Covered Persons unless:

- excluded by Us when this Policy was issued; or
- coverage ends according to the terms of this Policy.

Premium due for Eligible Dependent coverage must be paid.

For an Eligible Dependent not listed on the Application to be covered under this Policy as a Covered Person, You must apply to Us in writing. You must include evidence of insurability for any such Eligible Dependent. Your Plan Type must be the type that would allow for such Eligible Dependent to be covered. Coverage is only effective if approved by Us. If coverage is approved by Us, it will be made effective at 12:01 a.m. standard time in the Covered Person's state of residence on the date We approved it.

If You wish to change the Plan Type You chose on the Application thereby changing coverage options, You must notify Us in writing and pay any required Premium. Premium rates vary depending on Age and Plan Type. A Plan Type change is only effective if approved by Us.

Dependent Child

If Your Plan Type allows, a Dependent Child may be added as a Covered Person while this Policy is in force. You must apply in writing and include evidence of insurability for each such Dependent Child. Required Premium for this Dependent Child's coverage must be paid. Coverage is only effective if approved by Us.

A newborn or adopted child may be added as a Covered Person. Application for a newborn child must be made within 90 days of the date of birth. Application for a child for whom the Primary Insured or Primary Insured's spouse filed a petition to adopt must be made within 60 days of the date of petition. Coverage for such newborn or adopted child will be effective as of the date of birth, adoption or placement for adoption.

Subsequent Spouse

If Your Plan Type allows, the Primary Insured's subsequent spouse may be added as a Covered Person while this Policy is in force. You must apply in writing and include evidence of insurability for this spouse. Required Premium for this spouse's coverage must be paid. Coverage is only effective if approved by Us.

Disabled Child

A Dependent Child who becomes Disabled while he or she is a Covered Person under this Policy, may continue to be covered by this Policy after his or her coverage as a Dependent Child would otherwise end, as long as he or she:

- is and remains unmarried;
- is and continues to be Disabled; and
- has not contributed more than one-half toward his or her own support during the prior Calendar Year.

The proper Premium must continue to be paid.

We require proof that such Dependent Child is Disabled.

We must receive:

- a copy of the Primary Insured's or Primary Insured's spouse's most recent tax return showing this child as a dependent; or
- a copy of the Social Security disability certification for this child.

We may also require a doctor's statement regarding the nature and severity of the disability.

Such proof will not be required more frequently than annually.

In no event will coverage for any Covered Person continue beyond the date that this Policy ends.

CONVERSION

Conversion is the right of Eligible Dependents who are Covered Persons under this Policy to have a new policy issued when certain events occur, as stated below. Covered Persons who are 70 years of Age or older are not eligible to be covered by a Conversion Policy.

Spouse (if covered)

The Primary Insured's spouse, if a Covered Person less than 70 years of Age, shall be entitled without evidence of insurability to a Conversion Policy when:

- the Primary Insured and this spouse divorce;
- the Primary Insured turns 70 years old;
- coverage for such spouse ends at the request of the Policy Owner; or
- the Primary Insured dies.

To exercise this conversion right and have a Conversion Policy issued, written application for the new policy along with payment of the correct Premium must be made to Us within 60 days after the date this spouse's coverage ends due to the event giving rise to the right of conversion. The Termination of Coverage section of this Policy states when coverage ends.

Such covered spouse can also apply for coverage under his or her new policy without evidence of insurability for those Dependent Children less than 70 years of Age who are Covered Persons under this Policy at the time of conversion.

Dependent Children (if covered)

Each Dependent Child, if a Covered Person less than 70 years of Age, shall be entitled without evidence of insurability to a Conversion Policy when:

- the Primary Insured and a covered spouse divorce;
- the Primary Insured turns 70 years old;
- coverage for such Dependent Child ends at the request of the Policy Owner;
- the Primary Insured dies; or
- when such Dependent Child's coverage otherwise ends as stated in the Termination of Coverage section of this Policy, except when coverage ends because of lapse due to Premium not being paid by the end of the Grace Period.

To exercise this conversion right and have a Conversion Policy issued, written application for the new policy along with payment of the correct Premium must be made to Us within 60 days after the date the Dependent Child's coverage ends due to the event giving rise to the right of conversion. The Termination of Coverage section of this Policy states when coverage ends.

For any Disabled Dependent Child or Dependent Child who may not lawfully contract due to age or other incapacity, the written application for the Conversion Policy can be made by his or her parent or legal guardian.

Conversion Policies

No Conversion Policy will be issued covering any Covered Person whose coverage ends under this Policy because this Policy lapsed due to non-payment of Premium within the Grace Period.

The following applies to every Conversion Policy:

- any time requirements, such as Waiting Periods, satisfied in this Policy will not be required again in such new policy;
- no benefits for a loss or part of a loss that has been paid under this Policy will be paid under such new policy;
- any Covered Person who is covered under a Conversion Policy will no longer be covered under this Policy;
- Dependent Children can only be covered under one Conversion Policy and may not be a Covered Person under more than one policy issued under any conversion rights provided by this Policy; and
- premiums will be based on the person's Age at the time of conversion.

Election of Coverage

No person can be covered under a Conversion Policy and be covered under this Policy. By choosing to exercise a conversion right and have a new policy issued, all persons covered under such new policy acknowledge that when coverage starts under the Conversion Policy, coverage under this Policy ends, unless coverage ends sooner as stated in this Policy.

PREMIUMS, CHANGE IN PREMIUMS

Premium Payments

To keep this Policy in force and avoid lapse, You must pay each Premium due before the end of the Grace Period. If Premium is paid that would pay Premiums past the end date of this Policy, We will refund the excess Premium amount.

Premium amounts are based on the Plan Type, benefits You chose, gender, the Primary Insured's Age on the Date of Policy and state of residence. Premiums for any other benefit riders attached to this Policy will be assigned to the same Premium class. Your Premium can be changed for the following reasons:

- if We change the Premium on all policies in the same Premium class;
- if You choose and We approve a change in Plan Type; or
- if Your state of residence changes.

If We change the Premium on all policies in the same Premium class, We will give 60 days written notice before such Premium change occurs. Any increase or decrease will start on the Premium due date no sooner than 60 days after the notice is given.

If You choose and We approve a change in Plan Type or if Your state of residence changes, any increase or decrease will start on the Premium due date following the change in Plan Type or state of residence.

TERMINATION OF COVERAGE

This Policy ends and coverage for all Covered Persons ends the earliest of:

- the date the last Premium was due if You fail to pay each Premium due by the end of the Grace Period;
- when You request in writing that this Policy be canceled;
- the Policy Anniversary date after the Primary Insured's 70th birthday; or
- the date of the Primary Insured's death.

If this Policy ends for any reason, coverage for every Covered Person ends.

If a Covered Person will be covered by a Conversion Policy, that Covered Person's coverage under this Policy will end the day before coverage starts under such Conversion Policy.

Spouse (if covered)

Coverage for the Primary Insured's spouse, if a Covered Person, will end the earliest of:

- the date of the Primary Insured's death;
- the date when the Primary Insured and this spouse divorce;
- the Policy Anniversary date after the Primary Insured's 70th birthday;
- the Policy Anniversary date after this spouse's 70th birthday;
- the date when coverage for such spouse ends at the request of the Policy Owner; or
- the date the last Premium was due for Premium due not paid by the end of the Grace Period.

Dependent Children (if covered)

Coverage for each Dependent Child, if a Covered Person, will end the earliest of:

- the date of the Primary Insured's death;
- the Policy Anniversary date after the Primary Insured's 70th birthday;
- the date when coverage for such Dependent Child ends at the request of the Policy Owner;
- the date when such Dependent Child turns 18 years old, unless such Dependent Child continues to be a full-time student or unless coverage is continued as a Disabled Dependent Child as stated in this Policy;
- the date each such Dependent Child 18 years of Age or older but less than 26 years of Age ceases to be a full-time student, unless coverage is continued as a Disabled Dependent Child as stated in this Policy;
- the date when such Dependent Child turns 26 years old, unless coverage is continued as a Disabled Dependent Child as stated in this Policy;
- the date such Dependent Child marries;
- when such Dependent Child has contributed more than one-half toward his or her own support during the prior Calendar Year;

- the date when such Dependent Child is no longer Disabled, if coverage has been continued for this Dependent Child beyond 26 years of Age as a Disabled Dependent Child;
- the Policy Anniversary date after the Dependent Child's 70th birthday, if coverage has been continued for this Dependent Child beyond 26 years of Age as a Disabled Dependent Child; or
- the date the last Premium was due for Premium due not paid by the end of the Grace Period.

A Covered Person's coverage ends effective at 12:00 midnight standard time in his or her state of residence on the coverage end date.

GENERAL PROVISIONS

Assignment

No assignment of this Policy by You is allowed. Benefits may be assigned. No assignment of benefits is effective until received by Us in writing. We are not responsible for the validity of any assignment of benefits made.

Conformity with State Statutes

Any Policy term that is in conflict with the statutes of the state in which this Policy was issued is hereby amended to meet the minimum requirements of such statute(s).

Entire Contract

This Policy includes:
- the Application;
- the Policy Schedule;
- any endorsement or amendment;
- any attached rider;
- any application for reinstatement, if the Policy is reinstated after lapse; and
- any application adding a Covered Person.

This Policy constitutes the entire contract between Us and You.

Changes

No change in this Policy shall be valid unless made by endorsement or amendment. Such a change is valid only if signed by Our Chairman or Our President. No other person can waive any Policy terms or make any agreements about this Policy that are binding on Us.

Grace Period

This Policy has a 31 consecutive day Grace Period. The Grace Period starts on the day the Premium is due. This Policy is in force during the Grace Period. As long as each Premium due is paid within the Grace Period, this Policy will stay in force. If the Premium due is not paid within the Grace Period, then this Policy will lapse and all coverage ends the date the last Premium was due.

Legal Actions

Legal action cannot be taken against Us:
- sooner than 60 days after due Proof of Loss has been submitted to Us; or
- more than 3 years after the time written Proof of Loss is required to be filed according to the terms of this Policy.

Misstatement of Age

If a Covered Person's Age is misstated when coverage was applied for, Premiums will be recalculated based upon this Covered Person's correct Age. You will have to pay any additional Premium due. In the event the additional Premium due is not paid, this amount due may be deducted from benefits due.

Non-participating

This Policy is issued on a non-participating basis and will not share in Our surplus or earnings, nor pay dividends.

Physical Exams

We, at Our own expense, will have the right to have any Covered Person examined by a healthcare professional of Our choice during the pendency of a claim. This right may be exercised as often as reasonably required.

Reinstatement of this Policy

If this Policy ends because the Premium due was not paid by the end of the Grace Period and You want this Policy in force again, You must apply for reinstatement.

To request reinstatement, You must:

- submit a written application to Us;
- provide evidence of insurability for each Covered Person; and
- pay past due Premium.

The Policy will only be reinstated if approved by Us. No reinstatement will be considered after one year from the date of lapse.

If We have not provided written notice of Our decision to deny Your application for reinstatement by the 45th day after the date We received it, the Policy will be reinstated. Proper Premium must be sent to Us with the application for reinstatement.

Premium accepted for a reinstatement will be applied to the 31 day Grace Period that started the date of lapse and applied to the first month's premium due for the reinstated Policy. No Premium will be applied to an earlier period. If Your Policy is not reinstated, Premium received with Your application for reinstatement will be returned.

If this Policy is reinstated, only Injuries sustained after the date of reinstatement and loss due to Sickness that starts more than 10 days after the date of reinstatement are covered. In all other respects, Your rights and Our rights will remain the same, subject to any terms noted on or attached to the reinstated Policy.

Return of Unearned Premium

If the Primary Insured dies and Premium was paid in advance, Premium paid past the end of the month in which death occurred will be refunded upon notice to Us. A certified copy of the death certificate will be required.

Any unearned Premium returned will be paid to You. If You are the Primary Insured, then to Your estate, or to Your beneficiary if You have named a beneficiary for this Policy.

Time Limit on Certain Defenses

No misstatements, except fraudulent ones, made by You in the Application for this Policy can be used to deny a claim for a loss incurred by a Covered Person after two years from the Date of Policy.

No misstatements, except fraudulent ones, contained in any application submitted after the Date of Policy can be used to deny a claim for a loss incurred by a Covered Person after two years from the date We received it.

Change of Beneficiary

You may change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

KANAWHA INSURANCE COMPANY

[210 S. WHITE STREET]
[LANCASTER, SC 29720]

[PO BOX 610]
[LANCASTER, SC 29721-0610]

TELEPHONE: [877-207-0158]

HOSPITAL CONFINEMENT DAILY BENEFIT RIDER

PLEASE READ THIS RIDER CAREFULLY. This Rider is attached to and a part of Your Policy. All terms of Your Policy apply to this Rider, unless stated otherwise.

This Rider provides for the payment of a daily benefit due to a Covered Person's Hospital Confinement.

Rider Date

This Rider's effective date is the same as the Date of Policy[.][,][if this Rider was attached to Your Policy when it was issued.] [If this Rider was not attached when Your Policy was issued, the effective date of this Rider is the date We approved it.]

Covered Persons

Covered Persons under Your Policy are covered by this Rider. When a Covered Person's coverage under Your Policy ends, that Covered Person's coverage under this Rider ends.

DEFINITIONS

Full Day means a period of at least 18 continuous hours that spans two calendar days.

Intensive Care Unit / ICU means a designated area in a Hospital that is called an Intensive Care Unit.

The ICU must be:
- limited to persons who are critically injured or ill and require the highest level of care;
- equipped with specialized lifesaving equipment for the care of critically injured or ill persons;
- staffed 24 hours per day by a specially trained nursing staff;
- supervised 24 hours per day by a Doctor; and
- licensed by the state as an ICU.

An ICU does not include:
- rooms, beds and wards normally used for non-critical patient care;
- surgical suites and recovery rooms;
- Hospital Sub-Acute Intensive Care Units;
- a Hospital Observation Unit; or
- a unit located outside of the United States or its territories.

BENEFITS

Hospital Confinement Daily Benefit

We will pay the Hospital Confinement Daily Benefit Amount shown on the Policy Schedule for each Full Day of a Covered Person's Hospital Confinement. No benefits are provided or paid for more than 30 Full Days per each Hospital Confinement.

Intensive Care Unit Daily Benefit

We will pay the Intensive Care Unit (ICU) Daily Benefit Amount shown on the Policy Schedule for each Full Day of a Covered Person's Hospital Confinement that he or she is a patient in the Hospital's ICU. No benefits are provided or paid for more than 30 Full Days per each Hospital Confinement.

The benefits of this Rider are paid to the Primary Insured, unless assigned.

This Rider only provides benefits if the Hospital Confinement Lump Sum Benefit Amount is payable under Your Policy for the Hospital Confinement.

To pay benefits under this Rider, We must receive:

- written notice of claim;
- Proof of Loss; and
- Hospital records that includes:
  - dates and times of admittance and discharge; and
  - dates and times the Covered Person was a patient in the ICU, if applicable.

Payments made by Us under this Rider are in addition to any other benefits provided by Your Policy or other rider.

LIMITATIONS

Benefits of this Rider are only payable while Your Policy and this Rider are in force.

For each Full Day of a Covered Person's Hospital Confinement that he or she is a patient in the Hospital's ICU, We will only pay the Intensive Care Unit (ICU) Daily Benefit Amount. We will not pay both the Intensive Care Unit (ICU) Daily Benefit Amount and the Hospital Confinement Daily Benefit Amount for the same Full Day.

Waiting Period(s)

Six Months

No benefits are provided or paid under this Rider for care or treatment that occurs during the first six (6) months from the effective date of this Rider due or related to (unless on an emergency basis):

- cancer;
- hernia(s); or
- adenoids, tonsils or appendix.

Ten Months

No benefits are provided or paid under this Rider for care or treatment that occurs during the first ten (10) months from the effective date of this Rider due or related to:

- pregnancy; or
- childbirth.

Twelve Months

No benefits are provided or paid under this Rider for care or treatment of a Covered Person donating an organ that occurs during the first twelve (12) months from the effective date of this Rider.

EXCLUSIONS

No benefits are provided or paid under this Rider for any loss, expense, care or treatment due or related to:

- intentionally self-inflicted Injury;
- suicide or any attempted suicide, whether sane or insane;
- mental or emotional disorders without demonstrable organic disease;
- Injury or Sickness incurred as a result of engaging in an illegal occupation;
- voluntary ingestion, injection, inhalation or use of any drug, narcotic or sedative, unless prescribed by and taken in accordance with the directions of the prescribing Physician;
- voluntary ingestion, injection, inhalation, taking, absorbing or use of any poison, poisonous gas, fumes or any other substance that results in Injury or Sickness;
- being intoxicated as intoxication is defined by the laws of the state in which the incident occurred;
- alcoholism or drug addiction;
- war, whether declared or undeclared;
- cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to trauma, infection or other diseases of the involved part; and reconstructive surgery because of congenital disease or anomaly of a covered Dependent Child which has resulted in functional defect;
- elective surgery not medically necessary, other than organ donation and complications related to organ donation after the appropriate Waiting Period;
- dental services or dental treatments unless necessitated by trauma or Injury;
- Injury or Sickness incurred as a result of being engaged as a paid athlete;
- participation in a riot, felony or insurrection;
- travel in, on or descending from any kind of aircraft, unless as a fare paying passenger on a commercial airline, passenger on a private airline charter or as a passenger on a privately owned and operated airplane that seats more than 10 passengers;
- sky diving;
- eye examinations, eye glasses, hearing aids or the fitting thereof; or
- care or treatment received outside of the United States or its territories.

The following which may be associated with or related to pregnancy are excluded from coverage under this Rider. This Rider does not provide or pay benefits for any care, treatment or claim due or related to:

- an elective abortion;
- false labor;
- occasional spotting;
- Physician prescribed rest; or
- morning sickness.

Complications of pregnancy will be treated the same as any other Sickness.

Pre-existing Condition Exclusion – Except for congenital anomalies of a covered Dependent Child, no benefits are provided or paid under this Rider for any loss, care or treatment that occurs during the first 12 months of this Rider for any Pre-existing Condition.

TERMINATION

This Rider ends and coverage under this Rider for all Covered Persons ends:

- the date Your Policy lapses or otherwise ends; or
- when You make written request to cancel this Rider.

A Covered Person's coverage under this Rider ends the date that such Covered Person's coverage under Your Policy ends.

Signed for the Company.

[ ]

[President]

Application for Hospital Indemnity
Kanawha Insurance Company

HUMANA
Guidance when you need it most

PLEASE INDICATE: ○ NEW COVERAGE ○ CHANGE TO EXISTING COVERAGE ○ CONVERSION

Person(s) Proposed for Coverage

Primary Insured (Please Print)

First Name | MI | Last Name | Suffix

Birthdate (MM/DD/YYYY) | Height (Ft-In) | Weight | Social Security Number | Gender ○ Male ○ Female

Address (Street or R.R.)

City | State | ZIP Code

Home Telephone

( ) -

Spouse

Spouse Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) | Height (Ft-In) | Weight | Social Security Number | Gender ○ Male ○ Female

Child One

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) | Height (Ft-In) | Weight | Social Security Number | Gender ○ Male ○ Female

Child Two

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) | Height (Ft-In) | Weight | Social Security Number | Gender ○ Male ○ Female

Child Three

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) | Height (Ft-In) | Weight | Social Security Number | Gender ○ Male ○ Female

[210 South White Street, Lancaster SC 29720
Mail: Post Office Box 7777, Lancaster SC 29721-7777 1-877-207-0158]

BENEFIT SECTION

Plan Type ○ Individual (adult or child) ○ Family (2 parents and all children) ○ Single Parent (parent and all children)

Base Benefit ○ $250 ○ $500 ○ $1,000 ○ $1,500 ○ $2,000

Optional Benefit: Hospital Confinement Daily Benefit Rider / Intensive Care Unit (ICU) Daily Benefit

○ $50/day ($200/day if ICU) ○ $100/day ($400/day if ICU) ○ $200/day ($800/day if ICU)

Payment Method ○ Bank Draft ○ Credit Card ○ Direct Bill/Check (Annual Billing Only)
(Complete Bank Draft or Credit Card Authorization. Annual fee of $12.00 applies to credit card billing.)

Payment Mode ○ Monthly ○ Semi-annual ○ Annual **Total Modal Premium** $ ___ . ___

APPLICANT'S REPRESENTATION AND AGREEMENT

	Primary Insured	Spouse	Child 1	Child 2	Child 3
	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
1. Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession as having:					
a. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive to the antibodies for Human Immunodeficiency Virus (HIV).....	○ ○	○ ○	○ ○	○ ○	○ ○
b. Alzheimer's Disease.....	○ ○	○ ○	○ ○	○ ○	○ ○
c. Senile dementia.....	○ ○	○ ○	○ ○	○ ○	○ ○
d. Uncorrected congenital heart defect (excluding mitral valve prolapse).....	○ ○	○ ○	○ ○	○ ○	○ ○
e. Kidney disease (not including kidney stones).....	○ ○	○ ○	○ ○	○ ○	○ ○
f. Systemic lupus.....	○ ○	○ ○	○ ○	○ ○	○ ○
g. Insulin-dependent diabetes.....	○ ○	○ ○	○ ○	○ ○	○ ○
h. Liver disease or disorder (excluding Hepatitis A).....	○ ○	○ ○	○ ○	○ ○	○ ○
2. a. Is any person proposed for coverage currently confined in a hospital, nursing home, or any medical facility?.....	○ ○	○ ○	○ ○	○ ○	○ ○
b. Has a member of the medical profession recommended hospitalization, surgery, or nursing home confinement that has not yet occurred?.....	○ ○	○ ○	○ ○	○ ○	○ ○
3. Within the last 5 years has any person proposed for coverage been diagnosed or treated by a member of the medical profession for internal cancer (except basal cell cancer)?.....	○ ○	○ ○	○ ○	○ ○	○ ○
4. Within the past 2 years has any person proposed for coverage been hospitalized or seen in an emergency room by a member of the medical profession for:					
a. Angioplasty, stent placement, heart surgery.....	○ ○	○ ○	○ ○	○ ○	○ ○
b. Angina (heart related chest pain), heart attack, hypertension, congestive heart failure, peripheral vascular disease (circulatory problems).....	○ ○	○ ○	○ ○	○ ○	○ ○
c. Emphysema, chronic lung disease, asthma	○ ○	○ ○	○ ○	○ ○	○ ○
d. Cerebral vascular accident (CVA, stroke), cerebral vascular insufficiency, transient ischemic attack (TIA, ministroke).....	○ ○	○ ○	○ ○	○ ○	○ ○
e. Type II diabetes.....	○ ○	○ ○	○ ○	○ ○	○ ○
f. Parkinson's Disease.....	○ ○	○ ○	○ ○	○ ○	○ ○
g. Crohn's Disease, ulcerative colitis.....	○ ○	○ ○	○ ○	○ ○	○ ○
h. Sickle cell anemia.....	○ ○	○ ○	○ ○	○ ○	○ ○
i. Transplants.....	○ ○	○ ○	○ ○	○ ○	○ ○

5. Does any person proposed for coverage have any other Hospital Indemnity coverage in force or an application for similar insurance pending with this or any other company?..... ○ Yes ○ No
If "YES", please provide details with specific benefit amounts below.

6. Will the policy applied for replace any coverage currently in force?..... ○ Yes ○ No
If "YES", please complete the following.
Company Person Covered Policy Number

Payor Information

Payor Information (First, MI, Last Name) (If different than the Proposed Insured) Suffix

Social Security Number

- -

Address (Street or R.R.)

City State ZIP Code

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud.

I have read or had read to me all the questions on this Application and I represent the answers and any information provided are correct and complete to the best of my knowledge and belief. I also realize that any false statements or misrepresentation may result in loss of coverage under the policy subject to the time limit on certain defenses or incontestability provisions of the policy. I understand and agree that the policy will not take effect unless it is issued by Kanawha Insurance Company, the total modal premium must accompany Application, and any check, bank draft or credit card payment is honored on first presentation. No agent or producer has the authority to waive any of the conditions or questions in this Application.

I acknowledge, if required in my state, that I have been furnished:

☐ Outline of Coverage ☐ Medicare Buyer's Guide (If age 65 or over)

Signed At _____
City

State

_____
Signature of Primary Insured/Owner
(Parent or Guardian if Child only coverage)

/ /
Date (MM/DD/YYYY)

FOR INSURANCE PRODUCER'S USE ONLY

I certify any information recorded by me on this Application is true and accurate to the best of my knowledge and belief.

Will this insurance replace any existing insurance?..... ○ Yes ○ No

Date (MM/DD/YYYY)

Signature of Licensed Insurance Producer _____ / /

Printed Name of Licensed Insurance Producer _____

Insurance Producer Number	% Credit	Insurance Producer Number	% Credit	Insurance Producer Number	% Credit

AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT

Attach Voided Check

Name of Depositor (First, MI, Last Name) (Attach Voided Check) Suffix

Route and Transit Number

Account Number

Bank Name and Address

Debit on the ____ day of the month (1-28 only; 29, 30, 31 not available). **If no election is made, debits will be made on the day of Policy.**

As a convenience to me, I request and authorize **KANAWHA INSURANCE COMPANY** to make deductions automatically every payment period for payments of premiums from my: ○ savings account ○ checking account

1. Each debit shall constitute proper notice of premium due and will be made on the day selected above or, if no day is selected, the day of Policy.
2. This Authorization shall not become effective unless and until the coverage is issued.
3. This Authorization shall not be construed as modifying any provisions of the coverage.
4. Kanawha shall not incur any liability if a draft is returned unpaid by the bank. Drafts which do not clear within the time stipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage shall lapse subject to nonforfeiture provisions.
5. This Authorization may be discontinued by Kanawha or by the Undersigned at any time within FIVE (5) business days prior to the debit date. Upon termination of this Authorization, the premiums on the Policy covered will be payable annually.
6. Kanawha will notify me TEN (10) days prior to any changes in payment amounts.

Signature of Depositor _____ Date (MM/DD/YYYY) ____ / ____ / ____

CREDIT CARD INFORMATION

Card Holder Information

Credit Card Number

Expiration Date (MM/YY) ____ / ____

Card Type ○ Visa ○ Mastercard

3 or 4-digit security code found on the back of most cards:

Signature of Card Holder_____ Date (MM/DD/YYYY) ____ / ____ / ____

Name as it appears on the credit card statement (If different from Proposed Insured).

Card Holder (First Name, MI, Last Name) Suffix

All charges will be made on the day of Policy.

As a convenience to me, I request and authorize **KANAWHA INSURANCE COMPANY** to charge my credit card every payment period for payment of premiums.

1. Each charge shall constitute proper notice of premium due.
2. This Authorization shall not become effective unless and until the Policy is issued.
3. This Authorization shall not be construed as modifying any provisions of the Policy.
4. Kanawha shall not incur any liability if the credit card company does not honor the charge and the Policy shall lapse subject to nonforfeiture provisions.
5. This Authorization may be discontinued by Kanawha or by the undersigned at any time within FIVE (5) business days prior to the payment date. Upon termination of this Authorization, premiums for the Policy will be payable annually.
6. Kanawha will notify me TEN (10) days prior to any changes in payment amounts.

Signature of Card Holder _____ Date (MM/DD/YYYY) ____ / ____ / ____

KANAWHA INSURANCE COMPANY

[210 S. WHITE STREET]
[LANCASTER, SC 29720]

[PO BOX 610]
[LANCASTER, SC 29721-0610]

TELEPHONE: [877-207-0158]

OUTLINE OF COVERAGE
FOR HOSPITAL INDEMNITY POLICY FORM 90840 AR

A LIMITED BENEFITS POLICY

PLEASE READ YOUR POLICY CAREFULLY. This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract. Only the actual Policy terms will control. The Policy itself states the rights and duties of both You and Kanawha Insurance Company ("Kanawha"). The Policy also states the benefits and requirements. It is therefore important that **YOU READ YOUR POLICY CAREFULLY!** Please contact Us if You have questions.

LIMITED BENEFITS COVERAGE. Policies of this type are designed to provide covered persons with limited or supplemental coverage. The Benefits Summary section below outlines the coverage provided by the Policy. Benefits described in the Benefits Summary may be limited by the Limitations and Exclusions sections, and other terms in Your Policy.

NO RECOVERY FOR PRE-EXISTING CONDITIONS. Except for congenital anomalies of a covered Dependent Child, no benefits will be provided during the first 12 months of the Policy and any attached Rider for any Pre-existing Condition, as defined in the Policy.

BENEFITS SUMMARY

Hospital Confinement Lump Sum Benefit. If a Covered Person is confined as an inpatient in a Hospital for the treatment of an Injury or Sickness, Kanawha will pay the Hospital Confinement Lump Sum Benefit Amount shown on the Policy Schedule. This benefit is subject to a maximum of one Hospital Confinement for each Covered Person each Calendar Year. Other maximums may apply as well.

Hospital Confinement Lump Sum Benefit Amount: [$500]

Emergency Room Treatment Lump Sum Benefit. If a Covered Person requires and receives Emergency Room Care in a Hospital emergency room due to an Injury or Sickness, Kanawha will pay the Emergency Room Treatment Lump Sum Benefit Amount shown on the Policy Schedule. This benefit is subject to a maximum of two Hospital emergency room visits for each Covered Person each Calendar Year. Other maximums may apply as well.

Emergency Room Treatment Lump Sum Benefit Amount: [$150]

Outpatient Surgery Lump Sum Benefit. If a Covered Person requires and undergoes an Outpatient Surgical Procedure due to an Injury or Sickness, Kanawha will pay the Outpatient Surgery Lump Sum Benefit Amount shown on the Policy Schedule. This benefit is subject to a maximum of two Outpatient Surgical Procedures for each Covered Person each Calendar Year. Other maximums may apply as well.

Outpatient Surgery Lump Sum Benefit Amount: [$150]

BENEFITS ARE PAYABLE SUBJECT TO ALL OF THE TERMS OF THE POLICY.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

GUARANTEED RENEWABLE. You can keep Your Policy until the Policy Anniversary date following the Primary Insured's 70th birthday. You must pay each Premium due before the end of the Grace Period. Your Premium can be changed if Kanawha changes the Premium on all policies in Your Premium class. Kanawha will give 60 days written notice before such Premium change starts. If You move, Your Premium may also change.

PREMIUM. Your first Premium is [$XXX.XX]. Your renewal Premium is stated below. Your Premium is subject to change as outlined above and as stated in Your Policy.

Modal Premium:	[$XXX.XX] [Month]
Payment Mode:	[Monthly Bank Draft]

If You have Rider coverage under Your Policy, the above stated Premium includes Rider coverage.

GRACE PERIOD. A Grace Period of 31 days is provided for payment of each Premium due, except for the first Premium. Coverage will remain in force during the Grace Period.

OPTIONAL HOSPITAL CONFINEMENT DAILY BENEFIT RIDER (FORM 90841 AR)

Rider benefits are provided as outlined below for Covered Persons under Your Policy if You have Rider coverage. You have Rider coverage if You applied for it, if such coverage is shown on the Policy Schedule and the Rider was issued attached to Your Policy. If this Rider was not attached to Your Policy when You received it, then the Rider coverage is not available to Covered Persons under Your Policy. This is only a summary of Rider benefits. The terms contained in the Rider will control. **PLEASE READ YOUR RIDER.**

Hospital Confinement Daily Benefit. For each Full Day a Covered Person is confined as an inpatient in a Hospital, Kanawha will pay the Hospital Confinement Daily Benefit Amount shown on the Policy Schedule. Kanawha will pay this daily amount up to a total of 30 Full Days for any one period of Hospital Confinement.

Hospital Confinement Daily Benefit Amount:	[$50]

Intensive Care Unit Daily Benefit. For each Full Day of a Covered Person's Hospital Confinement that he or she is a patient in the Hospital's Intensive Care Unit (ICU), Kanawha will pay the Intensive Care Unit (ICU) Daily Benefit Amount shown on the Policy Schedule, up to a total of 30 Full Days for any one period of Hospital Confinement.

Intensive Care Unit (ICU) Daily Benefit Amount:	[$200]

For each Full Day that a Covered Person is in the ICU, only the ICU Daily Benefit will be paid. The Hospital Confinement Daily Benefit and the Intensive Care Unit Daily Benefit will not both be paid for the same Full Day.

LIMITATIONS

Waiting Period(s)

Six Months

No benefits are provided or paid under the Policy or Rider for care or treatment occurring during the first six (6) months from the Date of Policy/Rider for the following (unless on an emergency basis):

- cancer;
- hernia(s); and
- adenoids, tonsils or appendix.

Ten Months

No benefits are provided or paid under the Policy or Rider for care or treatment occurring during the first ten (10) months from the Date of Policy/Rider for the following:

- pregnancy; and
- childbirth.

Twelve Months

No benefits are provided or paid under the Policy or Rider for care or treatment of any Covered Person donating an organ occurring during the first twelve (12) months from the Date of Policy/Rider.

EXCLUSIONS

No benefits are provided or paid under the Policy or Rider for any loss, expense, care or treatment due or related to:

- intentionally self-inflicted Injury;
- suicide or any attempted suicide, whether sane or insane;
- mental or emotional disorders without demonstrable organic disease;
- Injury or Sickness incurred as a result of engaging in an illegal occupation;
- voluntary ingestion, injection, inhalation or use of any drug, narcotic or sedative, unless prescribed by and taken in accordance with the directions of the prescribing Physician;
- voluntary ingestion, injection, inhalation, taking, absorbing or use of any poison, poisonous gas, fumes or any other substance that results in Injury or Sickness;
- being intoxicated as intoxication is defined by the laws of the state in which the incident occurred;
- alcoholism or drug addiction;
- war, whether declared or undeclared;
- cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to trauma, infection or other diseases of the involved part; and reconstructive surgery because of congenital disease or anomaly of a covered Dependent Child which has resulted in functional defect;
- elective surgery not medically necessary, other than organ donation and complications related to organ donation after the appropriate Waiting Period;
- dental services or dental treatments unless necessitated by trauma or Injury;
- Injury or Sickness incurred as a result of being engaged as a paid athlete;
- participation in a riot, felony or insurrection;
- travel in, on or descending from any kind of aircraft, unless as a fare paying passenger on a commercial airline, passenger on a private airline charter or as a passenger on a privately owned and operated airplane that seats more than ten (10) passengers;
- sky diving;
- eye examinations, eye glasses, hearing aids or the fitting thereof; or
- care or treatment received outside of the United States or its territories.

The following which may be associated with or related to pregnancy are excluded from coverage under the Policy or Rider and no benefits are provided or paid for any care, treatment or claim related to:

- an elective abortion;
- false labor;
- occasional spotting;
- Physician prescribed rest; or
- morning sickness.

Complications of pregnancy will be treated the same as any other Sickness.

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RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 90840 AR

Signature of Applicant	**Date**
Signature of Licensed Resident Agent	**Date**

THIS PORTION RETAINED BY APPLICANT

RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 90840 AR

Signature of Applicant	**Date**
Signature of Licensed Resident Agent	**Date**

THIS PORTION RETAINED BY KANAWHA INSURANCE COMPANY

SERFF Tracking Number:	*SKML-126108237*	*State:*	*Arkansas*
Filing Company:	*Kanawha Insurance Company*	*State Tracking Number:*	*42484*
Company Tracking Number:	*90840*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/90840*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SKML-126108237*	*State:*	*Arkansas*
Filing Company:	*Kanawha Insurance Company*	*State Tracking Number:*	*42484*
Company Tracking Number:	*90840*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/90840*		

Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 06/02/2009

Comments:

Attachment:

AR Certification.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 06/02/2009

Comments:

The application the Company wished to use with the submitted program has NOT been previously approved and is included in the Forms Schedule for your review and approval with this submission.

Satisfied -Name: Outline of Coverage **Review Status:** Approved-Closed 06/02/2009

Comments:

The Outline of Coverage is a filed form and is submitted concurrently with this filing under the Forms Schedule section.

Satisfied -Name: Authorization Letter **Review Status:** Approved-Closed 06/02/2009

Comments:

Attachment:

Metlzer's auth.pdf

KANAWHA INSURANCE COMPANY

CERTIFICATION OF COMPLIANCE

ARKANSAS

Re: Hospital Indemnity Policy Form #90840 AR
Daily Hospital Indemnity Benefit Rider Form #90841 AR
Application Form 1664

With respect to submission of the above-referenced forms, KANAWHA INSURANCE COMPANY hereby agrees as follows:

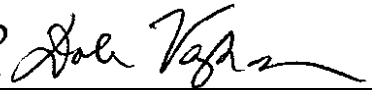
1. The Company will comply with the requirements of Rule and Regulation 19, concerning Unfair Sex Discrimination in the Sale of Insurance, when marketing these forms in the State of Arkansas.

2. The Company will comply with the requirements of Rule and Regulation 49 by providing a copy of the Life and Health Insurance Guaranty Association Notice to the Policy Owner.

3. The flesch test has been applied to the forms pursuant to ACA 23-80-206 and such forms produce a minimum flesch readability score of at least 40.0.

4. The Company will provide the Consumer Information Notice in compliance with ACA 23-79-138.

KANAWHA INSURANCE COMPANY

By 

R. Dale Vaughn, President

KMG AMERICA

210 South White Street
Post Office Box 610
Lancaster, SC 29721-0610

R. Dale Vaughan, CLU, CEBS, FLMI
President and Chief Operating Officer
Kanawha Insurance Company

Direct Line: 803-283-5490
dale.vaughan@kmgamerica.com

March 18, 2009

Ms. Sandra K. Meltzer, President
Sandra K. Meltzer & Associates, Inc.
1925 Century Boulevard, Suite 1
Atlanta, Georgia 30345

Re: NAIC 65110

Dear Ms. Meltzer:

Please accept this letter as authorization from Kanawha Insurance Company to your firm, Sandra K. Meltzer & Associates, Inc., to file any or all policy forms as referenced on the attached form listing on Kanawha's behalf.

Sincerely,

R. Dale Vaughan

Attachment